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## Who's picking up the bill?

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## Who's picking up the bill?

Interventions for oral care have significant health relevance with oral disease affecting an estimated 3.9 billion people worldwide. Daily adjusted life years (DALYs), a marker of the burden of oral disease, are estimated to have globally risen by 20% in the past 20 years as a consequence of population growth, demographic transition and changing dental disease patterns<sup>1</sup>. The costs of care delivery and maintenance continue to increase dramatically which in turn can have negative impacts on access to oral healthcare for older patients<sup>2</sup>. Current estimates indicate that treatment of oral disease accounts for 5% of public health spending across the European Union with annual treatment costs rising from €54 billion in 2000 to a projected €93 billion in 2020, a cost greater than the management of stroke and dementia combined. In their current form, global health systems are ill-prepared to cope with the escalating burden of care and its associated costs. There is evidence of inequality of access to oral healthcare services for many older people, with those over the age of 50 years experiencing income related barriers to preventive oral healthcare<sup>3</sup>. Accordingly, the financial cost of tooth loss disproportionately affects older age groups. There is a need for elderly patients, therefore, to achieve better clinical outcomes, which are also cost-effective. Unfortunately, to date very little health economics research has been targeted specifically towards dentistry<sup>4</sup>.

Natural teeth in the older population will be difficult and costly to manage despite benefits to food choice, quality of life and general health.<sup>3</sup> Frequently the treatment choices for older people who have lost teeth are confusing. Removable partial dentures (RPDs) can be expensive to make and difficult to maintain, and many are not used<sup>5</sup>. Implant retained prostheses are another approach to tooth loss, but they are very expensive and beyond the means of most publically funded healthcare programs,<sup>6</sup> and surgery frightens many people<sup>7</sup>. Replacement of all missing teeth may not be desired by or appropriate for everyone. Recently, treatment concepts have become functionally oriented to accept a reduced but healthy natural dentition based on a minimally invasive management of caries, and avoiding dentures<sup>8</sup>. From a public health viewpoint functionally oriented dentistry is particularly relevant to patients at moderate to high risk of caries and periodontal disease, and especially when access to treatment is difficult<sup>9</sup>.

Currently there is lack of coherence in policy making and evidence based guidelines for preventing oral diseases in older people.<sup>10</sup> We need equitable third party insurance schemes for oral healthcare in order to bridge the funding deficit in public funding<sup>11</sup>. Ideally, this should be based on effective, prevention-based oral healthcare in primary care settings which are easily accessible to all older patients. Global policy making for the older patient must integrate oral examinations with health screening programmes, and increase training of ancillary healthcare professionals to provide elements of preventive care to patients in a more affordable way<sup>12</sup>. In addition, remuneration systems should promote minimally invasive rather than complicated surgical and restorative treatments.

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